3-3 THE TREND FACTOR

The trend factor is a statistical measure of the change in the costs of goods and services purchased during the course of one year.

The trend factor has certain limitations as to its validity and applicability. It is not intended to be an exact measure of health center cost change. The index is subject to normal risk of errors in statistical sampling which may cause deviations from the true change in costs. Also due to the diversity of health centers' environments across the state, the trend factor may lose applicability to some providers. Another limitation exists due to the fact that there are factors which determine the trend which cannot be addressed when calculating the trend factor due to volatility or failure to identify.

Due to the similarities in costs of FQHC's and hospitals, the trend factor for FQHC's will be determined by the same method as that used for hospitals. One trend factor will be developed for all health centers in Mississippi. The method for determining the trend factor is described in Attachment 4.19-A of this state plan.

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3-4 DEFINITIONS

1. Core services - defined by OBRA 89, section 6404, to include physician services, services provided by nurse practitioners, clinical psychologists, clinical social workers, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services; and, to include in the case of an FQHC located in an area which is designated by the Mississippi State Department of Health to have a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment. Such written plan of treatment is to be established and periodically reviewed by a physician or established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician.

2. Visit - a face-to-face encounter between a center patient and a physician, nurse practitioner, clinical psychologist or clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers

illness or injury requiring additional diagnosis or treatment.

3. Allowable costs - costs that are incurred by a center and are reasonable in amount and proper and necessary for the efficient delivery of FQHC services.

CHAPTER 4

COST REPORT AND INSTRUCTIONS

4-1 INSTRUCTIONS

The cost reporting forms described in this chapter must be used by all FQHC's participating in the Mississippi Medicaid Program. Medicare (Title XVIII) cost reporting forms are not acceptable in lieu of these forms.

4-2 GENERAL INFORMATION

These instructions are for use in the preparation and submission of the Cost Report to the Division of Medicaid by all FQHC's providing care and services under the Medical Assistance Program.

The annual reports are the basis for determining reimbursement rates and cost settlement. A copy of all reports and statistical data must be retained by the facility for no less than five years following the date reports are submitted to the Division of Medicaid. All dollar amounts should be rounded to the nearest dollar. Rates and ratios will be rounded to two decimal places.

4-3 ANNUAL REPORTING

Reports are to be filed on or before the last day of the fifth month following the close of the reporting period. Should the due

date fall on a weekend, a State of Mississippi hoiday or a federal holiday, the due date shall be the first business day following such weekend or holiday. An extension of time for filing, not to exceed fifteen (15) days, may be granted by the Division of Medicaid. A request for an extension must be made in writing on or before the due date of the cost report.

The cost report must be filed in DUPLICATE together with copies of the following:

(a) working trial balance (2 copies)

(b) depreciation schedule (1 copy)

(c) any workpapers used to compute adjustments made in the cost reports (1 copy)

Both copies of the cost report filed with the Division of Medicaid must have original signatures on the Certificate by Officer or Administrator of Provider (Form 2).

The cost report and related information should be mailed to:

Division of Medicaid

Office of the Governor

Suite 801, Robert E. Lee Building

239 North Lamar Street

Jackson, MS 39201-1399

Cost reports must be postmarked on or before the due date or the extended due date in order to avoid a penalty in the amount of $50.00 per day the cost report is delinquent.

4-4 ACCOUNTING BASIS

The report must be prepared on the accrual basis of accounting. Particular attention must be given to accurate accrual of all costs at the year end for the equitable distribution of costs to the applicable period. Care must be given to the proper allocation of costs for service and maintenance contracts to the period covered by such contracts. Care should be given to a proper cutoff of accounts receivable and accounts payable both at the beginning and ending of the reporting year. Amounts earned although not actually received and amounts owed to creditors but not paid should be included in the reporting period. Amounts accrued in the prior

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period for reporting purposes should be deducted from the current period cost report.

4-5 SUPPORTING INFORMATION

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. The report is based on financial and statistical records which must be maintained by the facility for five (5) years. Cost information must be current, accurate, and in sufficient detail to support the claim for reasonable cost-related reimbursement. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. Such information must be adequate and available for auditing.

4-6 INSTRUCTIONS FOR COST REPORT FORMS

FORM 1 - GENERAL INFORMATION

I. Provider Name:

The true name of the health center as licensed by the Mississippi State Department of Health.

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Provider Number:

The center's Medicaid provider number in effect for the dates of the cost report.

D/B/A:

The name by which the Federally Qualified Health Center operates (complete only if different from provider name above).

Administrator:

The center's administrator at the close of the cost reporting period.

Contact Person:

The person employed by the center who should be contacted regarding the cost report.

II. Complete this section only if the health center has satellite clinics. Please attach a schedule if additional space is needed.

III. Do not complete this section.

FORM 2 - CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

The Certification by Officer or Administrator of Provider is required and must be signed by an authorized officer or the

administrator of the health center. The cost report will not be deemed received by the Division of Medicaid if this certification has not been completed.

The cost report may be completed by the center's employees, owners, independent accountants, or other qualified parties. If an independent Certified Public Accountant prepares the cost report, an Accountants' Report should be attached. Unaudited financial and statistical report schedules should be clearly marked as "unaudited" and should be accompanied by the appropriate compilation or review report.

FORM 3 - STATISTICAL DATA

Line 1

Please check the block which applies to your health center.

Line 2

FQHC Owner. Enter the name of the non-profit organization which controls the health center. Or, if the health center is controlled by a government, then please note that on this line.

Line 3

List all clinics, providers of services (including hospitals, long-term care facilities, or home health agencies), and

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suppliers that are owned, or related through common ownership or control, to the organization listed on Line 2.

Line 4

The accrual basis of accounting is required.

Line 5

List all physicians furnishing services during the cost report period at the health center, including all satellite clinics, as employees or under contractual agreement and their Medicaid provider number.

FORM 4 - RECLASSIFICATION & ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

All expenses for the period are to be listed on the appropriate line and in the appropriate column (1,2,or 3) and should agree with the expenses recorded on the center's trial balance after accrual adjustments.

Column Descriptions:

Column 1 Compensation Including Benefits. This column should include expenses for compensation by salary and should also include any related fringe benefits.

Column 2 Purchased and Contract Services. This column should include expenses for purchased and contract services including compensation by contractual agreement.

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